

Boyle *et al* refer to an “abrupt change in attitude towards the fetus in utero and the child ex utero at similar gestations” which “may lead to conflict.” In their case history they suggest that there is no alternative to full aggressive treatment for a child born at 25 weeks or later, and relate this to the acquisition of a higher moral status. This does not reflect practice north of the border as we have studied it. Here compassion and caution temper the use of technology and I found no evidence of the suggested “conflict”.

The authors propose a period of “intermediate parental rights” to cover the period between 24 and 26 weeks, giving parents the right to sanction limitation of treatment. Although I am uneasy about the linking of these rights to specific gestation periods, and I share the opinion of many eminent neonatologists that laws or rules in this area are unworkable and dangerous, I believe that parents do already have the facility to influence and be involved in treatment decisions during this period, just as the mother is before 24 weeks and both parents are after 26 weeks. In reality a practice prevails in Scotland where neonatal staff are in general sensitive to parental wishes and views at every gestation, and in my judgement this seems preferable to a system which accords rights to the parents that conflict with those of the baby.

All treatment carries risks and potential burdens, and choices have to be made. They will be made by fallible people who will not always get it right, but the alternative is to impose a rigid menu of decisions to be applied automatically. The consequences of that are too intolerable to contemplate. Doctors, lawyers, philosophers, and many others have long debated these issues, and the consensus has usually been that we can do no better than to encourage those with the most experience and expertise in these matters to negotiate sensitively in every case with those whose interests are most at stake, and strive to arrive at the best possible solution in these circumstances for this baby and his family at this time.

Issues of “a life not worth living” and just when a disability becomes intolerable are emotive ones and difficult

to determine. So much depends on the circumstances, knowledge, and experience of the assessor. In reality we found that the personal opinions of parents as to their own tolerances and attitudes are listened to. It is noteworthy that, of the parents who took part in our study, many referred to their own previous total ignorance of problems in the neonatal period, and as many as 78% said that their views and priorities had changed as the result of personal experience. It would then surely be ethically dubious for doctors to take parents’ initial gut reactions at face value in deciding whether or not to treat babies. There must be some effort made to give them an awareness of the risks of impairment, disability, and death as well as the potential consequences of their choices. Clinical judgements have to be made about just when information and recommendation override parental autonomy.

Of course neonatal intensive care is expensive. The care of damaged infants is a heavy drain on society. Healthcare professionals cannot ignore the issue of limited resources. However in our research it was clear that staff believe, and parents concur, that if wise moral decisions are to be made, these matters cannot be allowed to dictate medical choices at an individual level in the nursery or delivery room. This is a debate which belongs away from the cotside.

These are difficult decisions being made by fallible people, but the present system as we have observed it in Scotland seems preferable to a pursuit of medical treatment without true compassion and practical wisdom.

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## REFERENCES

- 1 **McHaffie HE**, Fowle PW. *Life, Death and Decisions: doctors and nurses reflect on neonatal practice*. Cheshire: Hochland and Hochland, 1996.
- 2 **McHaffie HE** in association with Fowle PW, Hume R, Laing IA, Lloyd DJ, Lyon AJ. *Crucial Decisions at the Beginning of Life: parents’ experiences of treatment withdrawal from infants*. Oxford: Radcliffe Medical Press, 2001.

## ECHO.....

### Necropsies have value in medical education



Please visit the *Journal of Medical Ethics* website [[www.jmedethics.com](http://www.jmedethics.com)] for a link to the full text of this article.

**M**edical educators in the UK still believe necropsy is a valuable educational resource despite recent negative publicity, curricular revisions and declining use of the procedure.

A “theoretical sample” of teaching staff from Sheffield University Medical School completed a semistructured private interview designed to clarify their personal attitudes towards necropsy. Similar statements were grouped together as themes, of which nine were identified at the completion of data gathering and included: a readiness of the participants to consent to their own necropsy; a high degree of clinical detachment from emotions linked to necropsy; and a willingness to consent to necropsy on a close relative. Some participants raised concern that necropsy objectified the human body, whilst others felt the procedure increased the respect paid to the deceased.

The wide range (and occasionally conflicting nature) of responses received in the study reflects the theoretical sampling undertaken. Interestingly, participants who would not give consent for a close relative to receive necropsy stated that it was due to their religious beliefs rather than any doubts about the educational value of necropsy.

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